# STATE OF CONNECTICUT
## DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

April 4, 2018

Mr. Vincent Capece, Jr, Administrator
Middlesex Hospital
28 Crescent St
Middletown, CT 06457

Dear Mr. Capece, Jr:

Unannounced visits were made to Middlesex Hospital on March 16, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation with additional information received through March 16, 2018.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for April 25, 2018 at 11:00am in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish to retain legal representation, your attorney may accompany you to this meeting.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by April 18, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

Connecticut Department of Public Health

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DATES OF VISIT: March 14, 15 and 16, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Alternate remedies to violations identified in this letter may be discussed at the office conference. In addition, please be advised that the preparation of a Plan of Correction and/or its acceptance by the Department of Public Health does not limit the Department in terms of other legal remedies, including but not limited to, the issuance of a Statement of Charges or a Summary Suspension Order and it does not preclude resolution of this matter by means of a Consent Order.

Should you have any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC/LD:jf

Complaint #23040

DATES OF VISIT: March 14, 15 and 16, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(A) and/or (j) Emergencies (2) and/or (i) General (6).

The following (is a / are) violation(s) of the Regulations of Connecticut State Agencies Section xxxxxxxxxxxx.

1. *Based on a review of the clinical record, hospital documentation and interviews for one of twenty-one patients (Patient #1) reviewed who either left the hospital against medical advice (AMA) or transferred to another facility, the hospital failed to ensure the patient received a medical screening examination. The findings include:
    a. Patient #1 was transported to Hospital #1's ED (Emergency Department) on 2/14/18 at 8:19 AM via Emergency Medical Service (EMS) #1 for complaints of shortness of breath (SOB) and chest pain. The ambulance run sheet dated 2/14/18 identified that Patient #1 arrived at Hospital #1's ED via EMS #1 at 8:19 AM. ED Medical Doctor (MD) #1 tried to divert EMS, however, the EMS ambulance had already arrived at ED #1's ambulance entrance. During transport via ambulance to Hospital #1's ED, Patient #1 required supportive respiratory interventions and the administration of sublingual nitroglycerine x 2 for respiratory difficulty and complaints of chest pain. Upon arrival to Hospital #1's ED, EMS personnel asked MD #1 to evaluate Patient #1 due to acute electrocardiogram (EKG) changes indicative of a STEMI (ST elevation myocardial infarction). Further review of the ambulance run sheet identified that after MD #1 evaluated Patient #1's EKG at 8:19 AM while patient was still in the ambulance. MD #1 instructed EMS to transport Patient #1 to Hospital #2's ED, indicating any delay in transfer would only delay time sensitive patient care/treatment. EMS personnel (Medic #1) requested a second medic to meet them for assistance. Medic #2 met Medic #1 at 8:27 AM and a third sublingual nitroglycerine was administered to Patient #1 at 8:42 AM. Patient #1 arrived at Hospital #2 at 8:52 AM with a total transfer time of 31 minutes from Hospital #1 to Hospital #2. Patient #1's medical record from Hospital #2 identified that the patient was evaluated at Hospital #2's ED on 2/14/18 with a heart rate of 131, blood pressure 150/90, respiratory rate of 24 and oxygen saturation of 94% on bi-pap. Patient #1 was diagnosed with an acute myocardial infarction, required intubation with mechanical ventilation and was subsequently admitted to the hospital. Patient #1's discharge summary dated 2/23/18 noted final diagnoses of acute pulmonary edema, hypertensive crisis, and new paroxysmal atrial fibrillation and coronary artery disease status post stent placements.

        Review of the ED record from Hospital #1 dated 2/14/18 failed to identify that a medical screening examination was conducted by the physician. Further review failed to indicate that the ambulance transport documentation for Patient #1's ED visit was not present in a medical record.

        Review of the clinical record and interview with the Chairman of Hospital #1's ED, Director of Quality, Manager of Regulatory Compliance and the ED Medical Director of Hospital #1 on 3/15/18 all identified that the hospital policy was not followed. Further interview identified that Patient #1 should have been assessed, stabilized and/or treated

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prior to transfer to Hospital #2. In addition, Hospital #2 was not notified of and/or accepted the transfer of Patient #1. Further review indicated that the ED record lacked a medical screening evaluation and/or medical record documentation.

During a review of the audio call between Secretary #1, EMS and/or MD #1 with Manager of Quality on 3/15/18 at 11:15 AM verified that the hospitals investigation of the chain of events prior to Patient #1's transfer from Hospital #1 to Hospital #2. No discrepancies in the above interviews were identified.

Review of the hospital's EMTALA policy indicated each patient presenting to the ED with an Emergency Medical Condition (EMC) is entitled to a medical evaluation and necessary stabilization.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D3 (c) Medical staff (2)(A) and/or (j) Emergencies (2) and/or (i) General (6).

2. *Based on a review of the clinical record, hospital documentation and interviews for one of twenty-one patients (Patient #1) reviewed who was transported to the Emergency Department with a medical condition, the hospital failed to ensure that the patient received a medical exam and treatment needed to stabilize a medical condition prior to transfer to another hospital. The findings include:

    b. Patient #1 was transported to Hospital #1's ED (Emergency Department) on 2/14/18 at 8:19 AM via Emergency Medical Service (EMS) #1 for complaints of shortness of breath (SOB) and chest pain. The ambulance run sheet dated 2/14/18 identified that Patient #1 arrived at Hospital #1's ED via EMS #1 at 8:19 AM. ED Medical Doctor (MD) #1 tried to divert EMS, however, the EMS ambulance had already arrived at ED#1's ambulance entrance. During transport via ambulance to Hospital #1's ED, Patient #1 required supportive respiratory interventions and the administration of sublingual nitroglycerine x 2 for respiratory difficulty and complaints of chest pain. Upon arrival to Hospital #1's ED, EMS personnel asked MD #1 to evaluate Patient #1 due to acute electrocardiogram (EKG) changes indicative of a STEMI (ST elevation myocardial infarction). Further review of the ambulance run sheet identified that after MD #1 evaluated Patient #1's EKG at 8:19 AM while patient was still in the ambulance. MD #1 instructed EMS to transport Patient #1 to Hospital #2's ED, indicating any delay in transfer would only delay time sensitive patient care/treatment. EMS personnel (Medic #1) requested a second medic to meet them for assistance. Medic #2 met Medic #1 at 8:27 AM and a third sublingual nitroglycerine was administered to Patient #1 at 8:42 AM. Patient #1 arrived at Hospital #2 at 8:52 AM with a total transfer time of 31 minutes from Hospital #1 to Hospital #2. Patient #1's medical record from Hospital #2 identified that the patient was evaluated at Hospital #2's ED on 2/14/18 with a heart rate of 131, blood pressure 150/90, respiratory rate of 24 and oxygen saturation of 94% on bi-pap. Patient #1 was diagnosed with an acute myocardial infarction, required intubation with mechanical ventilation and was subsequently admitted to the hospital. Patient #1's discharge summary dated 2/23/18 noted final diagnoses of acute pulmonary

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Review of the ED record from Hospital #1 dated 2/14/18 failed to identify that a medical screening examination was conducted by the physician. Further review failed to indicate that the ambulance transport documentation for Patient #1's ED visit was not present in a medical record.

Review of the clinical record and interview with the Chairman of Hospital #1's ED, Director of Quality, Manager of Regulatory Compliance and the ED Medical Director of Hospital #1 on 3/15/18 all identified that the hospital policy was not followed. Further interview identified that Patient #1 should have been assessed, stabilized and/or treated prior to transfer to Hospital #2. In addition, Hospital #2 was not notified of and/or accepted the transfer of Patient #1. Further review indicated that the ED record lacked a medical screening evaluation and/or medical record documentation.

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